Chapter 2 Revisions

Hardcopy Page Number	Change
7	Claim example: change date to 07012000. Add new bullet; Line item date of service and no HCPCS code
10	Add new bullet, Critical Access providers continue to bill surgical procedures utilizing bill type 85X
13	Revenue code for electroencephalogram (EEG) should be 74X, not 75X
14	Under 99291, remove observation room
15	Delete radiation therapy section, in the book twice
15	HCPCS code G0175, at the end of the last sentence, add but cannot be a nurse.
16	Change Radiation Therapy, to Sterotatic Radiosurgery Replace E0616 with C1361 and it qualifies for a pass through payment. L8614 qualifies for a pass through payment
18	Under “Special guidelines for radiology, delete 73,74
21	Under “Special guidelines for modifier 52 , first bullet add “and do not use modifier 52
22	Take out Payment Implications
23	Under DO NOT, change modifier 50 to 52
24	Delete examples and replace with anesthesia for procedure 38475, Axillary lymphadenectomy; complete is given and the procedure has been started, but the physician terminates the procedure before it is completed. This is billed as 3874574
27	Delete example 27236. Replace with procedure 26615 open treatment of metacarpal fracture, single, with or without internal or external fixation, each bone. Later in the recovery room the internal fixation pin is dislodged, so that the operating surgeon needs to repeat the procedure. This is reported as 26615 (first line) and 2661576 (next line). Both will have units reported as one. Change EKG example from 93000 to 93005
28	Surgical procedure example should correspond with narrative 360 26615 070100 1 360 2661576 070100 1
29	Delete example 44366 and replace with procedure 26615, open treatment of metacarpal fracture, single, with or without internal or external fixation, each bone. Later, while in the recovery room the internal fixation pin is dislodged, and a different surgeon repeats the procedure. This is reported

	as 26615(first line) and 2661577 (next line). Both will have units reported as one. 360 26615 070100 1 360 2661577 070100 1
30	Under “Use modifier 25 for an E$M service. Add to the last bullet “and is documented in the medical record Delete instructions “Do not use modifier 25 to report”
31	An example for modifier 58 is one were a needle biopsy is performed in the morning and the plan which is subsequently carried out, is to perform an excision biopsy later in the day depending on the results of the surgical pathology report
32	Delete example 33535. Replace with; 23500 Closed treatment of clavicular fracture with manipulation; and following this it is subsequently decided that another procedure is required, such as 23515, Open treatment of clavicular fracture, with or without internal or external fixation. This is reported as 23500 on the first line and 2351578 on the next line. The modifier 78 claim example should be as follows; 360 23500 070100 1 360 2351578 070100 1
32	Add , When reporting surgical procedures each revenue code must have charges associated with the revenue code reported
33	Delete example; Replace with Procedure 20100, Exploration of penetrating wound (separate procedure); extremity following later in the day by procedure 43227 esophagoscopy, rigid or flexible with control of bleeding, any method. The modifier 79 claim example should be as follows; 360 20100 070100 1 360 4322779 070100 1
36	Add modifier 52, When no anesthesia is used
38	Remove modifier 73 for Radiology
39	Remove modifier 74 for Radiology
41	Under modifier 25 take out DO NOT
42	Condition code G0 new sentence, Distinct and independent visits on the same day in the same revenue center can be reported on separate claims with condition code G0 on the second and any subsequent claims. New Claim examples: Condition Code G0 Billing Example 1 (one claim submitted) – One claim Condition code G0 is on the claim

	REV. CD HCPCS/RATES SERV.DATE SERV.UNITS. TOTAL CHARGES 450 99281 070100 2 800.00 Billing Example 2 (two claims submitted) REV. CD HCPCS/RATES SERV.DATE SERV.UNITS. TOTAL CHARGES 450 99281 070100 1 400.00 Claim Two (separate claim) Condition Code G0 REV. CD HCPCS/RATES SERV.DATE SERV.UNITS. TOTAL CHARGES 450 99281 070100 2 800.00 Claim One Billing Example 3 (three claims submitted) REV. CD HCPCS/RATES SERV.DATE SERV.UNITS. TOTAL CHARGES 510 99281 070100 1 400.00 Claim Two (separate claim) Condition Code G0 REV. CD HCPCS/RATES SERV.DATE SERV.UNITS. TOTAL CHARGES 510 99281 070100 1 400.00 Claim Three (separate claim) Condition Code G0 REV. CD HCPCS/RATES SERV.DATE SERV.UNITS. TOTAL CHARGES 510 99281 070100 1 400.00
43	Under outpatient claims submitted.. Change bullet three to read" The reporting of HCPCS codes in the range of 99217-99220 is optional.
44	The example should look like this 450 99281 320 70250
44	Add to the second bullet, 99291
45	Bullet 10 has an incorrect revenue code 331 should be 311
47	Change HCPCS code to 71020 and revenue code 320
50	Change example to a date after 070100

	Delete statement associated with NOTE; Service units are not required for drugs and biologicals (revenue code 250) Service units are required for Drugs and Biologicals
51	Change example to reflect 070500, 071200, 072900
53	Under Provider Reporting Requirements add after first sentence, All services performed on the same day must be billed on the same claim except; demand bills, condition code 20 or 21, repetitive services, condition code G0 Change June and July to July and August Under Corneal Tissue Acquisition Costs, the final sentence should read; Providers should report their charges for corneal tissue on the bill
64	Add, Please refer to HCFA web site at www.hcfa.gov new information is added to this list
65	Delete sentence “Reimbursement will be reduced …. On able 78267 and 78268 these are clinical fee schedule.
69	3rd bullet change to read, The costs exceed 2.5 times the OPPS payment. The outlier payment is calculated as 75% of the amount by which the claim cost exceed the cost threshold.